UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ADAGEN (pegademase bovine)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and opt._____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY

CRITERIA:

- **DOCUMENTED** diagnosis of Adenosine Deaminase Deficiency (ADA)
- Copy of prescription from physician
- Dose must be delivered in a pre-filled syringe for exact dosing
- Medicaid must be notified of changes in dosage with a copy of a new prescription.

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy